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# 2002 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2002)

### IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 4/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041	517		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER
Facility Name: Heritage Manor-Gillespie  Address: R.R. #2 P.O. BOX 3B Number  County: MACOUPIN  Telephone Number: (217 ) 839-2171  IDPA ID Number: 370909086017	Gillespie City  Fax # ( )	61701 Zip Code	I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.  Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.
Date of Initial License for Current Owners:  Type of Ownership:  VOLUNTARY,NON-PROFIT	03/01/96	] GOVERNMENTAL	Officer or Administrator of Provider  (Signed) (Date)  (CRAIG L. ATER (Date)  (Type or Print Name) CRAIG L. ATER (Title) Senior Vice President Finance
Charitable Corp. Trust	Individual Partnership	State County	(Signed)
IRS Exemption Code	Corporation xx "Sub-S" Corp. Limited Liability Co. Trust Other	Other	Paid (Print Name Preparer and Title) (Firm Name
In the event there are further questions about the Name: CRAIG L. ATER	his report, please contact: Telephone Number: ( )		& Address)  (Telephone) (309 )823-7135 Fax # ( )  MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Facility Name & I	D Number	Heritage Mai	nor-Gillespie				# 0041517 Report Period Beginning: 1/01/2002 Ending: 12/31/2002
III. STAT	ISTICAL I	DATA					D. How many bed-hold days during this year were paid by Public Aid?
A. Lic	ensure/cer	tification level(s) of	f care; enter number	of beds/bed days,			(Do not include bed-hold days in Section B.)
(mus	st agree wi	th license). Date of	change in licensed b	eds		_	
							E. List all services provided by your facility for non-patients.
1		2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
							NONE
Beds at					Licensed		
Beginning o	of	Licensu	re	Beds at End of	<b>Bed Days During</b>		F. Does the facility maintain a daily midnight census? YES
Report Perio	od	Level of	Care	Report Period	Report Period		
							G. Do pages 3 & 4 include expenses for services or
1	118	Skilled (SNI	,	118	43,070	1	investments not directly related to patient care?
2			atric (SNF/PED)			2	YES NO XX
3	0	Intermediat	\ /	0	0	3	
4		Intermediat				4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5	0	Sheltered C		0	0	5	YES NO XX
6		ICF/DD 16	or Less			6	I On what data did you start moniding lang town come at this location?
7	110	TOTALE		110	42.070	_	I. On what date did you start providing long term care at this location?
1	118	TOTALS		118	43,070	7	Date started <u>03/01/96</u>
							I Was the facility much and or lessed often January 1, 10709
R Cer	nsus_For th	e entire report per	ind				J. Was the facility purchased or leased after January 1, 1978?  YES Date 03/01/96 NO xx
1	1343-101 th	2	3	4	5		Date 05/01/70
Level of Car	••	<del>-</del>	•	d Primary Source of	-		K. Was the facility certified for Medicare during the reporting year?
Level of Car	· -	Public Aid	by Ecver of Care an		Tayment	-	YES NO xx If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified and days of care provided 2,803
8 SNF		19,071	14,531	2,803	36,405	8	and any, or one of provided
9 SNF/PED		,	- 1,000	0		9	Medicare Intermediary
10 ICF						10	
11 ICF/DD						11	IV. ACCOUNTING BASIS
12 SC		0	0	0		12	MODIFIED
13 DD 16 OR L	ESS					13	ACCRUAL XX CASH* CASH*
14 TOTALS		19,071	14,531	2,803	36,405	14	Is your fiscal year identical to your tax year? YES XX NO
			line 14 divided by to	tal licensed			Tax Year: Fiscal Year:
bed	l days on li	ne 7, column 4.)	84.53%	_			* All facilities other than governmental must report on the accrual basis.

STATE OF	STATE OF ILLINOIS					Page 3
	#	0041517	Danart Pariod Reginning	1/01/2002	Ending	12/31/2003

Facility Name & ID Number Heritage Manor-Gillespie				STATE OF ILI	0041517	Report Period Beginning: 1		1/01/2002	Ending:	12/31/2002		
	V. COST CENTER EXPENSES (through			the nearest do		0011017	report i criou	Deginning.	1/01/2002	Enumy.	12/01/2002	-
			osts Per Genera		,	Reclass-	Reclassified	Adjust-	Adjusted	FOR OH	USE ONLY	T
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	143,528	11,454		154,982		154,982	4,043	159,025			1
2	Food Purchase		142,682		142,682		142,682	(857)	141,825			2
3	Housekeeping	81,553	13,176		94,729		94,729		94,729			3
4	Laundry	40,062	13,747		53,809		53,809		53,809			4
5	Heat and Other Utilities			94,038	94,038		94,038	1,258	95,296			5
6	Maintenance	47,313	25,232	28,811	101,356		101,356	10,880	112,236			6
7	Other (specify):*											7
8	TOTAL General Services	312,456	206,291	122,849	641,596		641,596	15,324	656,920			8
	B. Health Care and Programs											
9	Medical Director			1,250	1,250		1,250		1,250			9
10	Nursing and Medical Records	1,233,532	58,170	12,315	1,304,017		1,304,017		1,304,017			10
10a	Therapy		194,464	79,380	273,844	(310,659)	(36,815)	103,987	67,172			10a
11	Activities	47,825	2,453	1,995	52,273		52,273		52,273			11
12	Social Services	28,081	608	3,198	31,887		31,887		31,887			12
13	Nurse Aide Training	3,628			3,628		3,628	2,248	5,876			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,313,066	255,695	98,138	1,666,899	(310,659)	1,356,240	106,235	1,462,475			16
	C. General Administration											
17	Administrative	65,915			65,915		65,915	104,490	170,405			17
18	Directors Fees							5,546	5,546			18
19	Professional Services			251,037	251,037		251,037	(240,596)	10,441			19
20	Dues, Fees, Subscriptions & Promotions			82,402	82,402	(64,605)	17,797	(2,895)	14,902			20
21	Clerical & General Office Expenses	90,568	7,644	17,983	116,195		116,195	219,782	335,977			21
22	Employee Benefits & Payroll Taxes			298,119	298,119		298,119	28,739	326,858			22
23	Inservice Training & Education			703	703		703	902	1,605			23
24	Travel and Seminar			5,794	5,794		5,794	(3,795)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			43,666	43,666		43,666	2,117	45,783			26
27	Other (specify):*			24,145	24,145		24,145	(24,064)	81			27
28	TOTAL General Administration	156,483	7,644	723,849	887,976	(64,605)	823,371	90,226	913,597			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,782,005	469,630	944,836	3,196,471	(375,264)	2,821,207	211,785	3,032,992			29
	*Attach a schodula if more than one two					(575,204)	2,021,207	211,703	3,032,772		1	- 27

\*\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

# V. COST CENTER EXPENSES (continued)

**Facility Name & ID Number** 

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			154,641	154,641		154,641	10,325	164,966			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			178,777	178,777		178,777	215	178,992			32
33	Real Estate Taxes			26,528	26,528		26,528		26,528			33
34	Rent-Facility & Grounds							7,930	7,930			34
35	Rent-Equipment & Vehicles			5,745	5,745		5,745	14,566	20,311			35
36	Other (specify):*											36
37	TOTAL Ownership			365,691	365,691		365,691	33,036	398,727			37
	Ancillary Expense											4
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					310,659	310,659		310,659			39
40	Barber and Beauty Shops		373	10,455	10,828		10,828		10,828			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					64,605	64,605		64,605			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		373	10,455	10,828	375,264	386,092		386,092			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,782,005	470,003	1,320,982	3,572,990		3,572,990	244,821	3,817,811			45

<sup>\*</sup>Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Heritage Manor-Gillespie

Facility Name & ID Number Heritage Manor-Gillespie

# 0041517

**Report Period Beginning:** 

1/01/2002

**Ending:** 

Page 5 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	Th Column	1 2 below, reference the	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES	Amount	ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,119)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(44)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(857)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(916)	20		17
18	Fines and Penalties				18
19	Entertainment	(10,818)	24		19
20	Contributions	(64)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(745)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)			24
25	Fund Raising, Advertising and Promotional	(6,279)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
	Other-Attach Schedule Real estate taxes		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (44,842)	)	\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

			2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	289,663		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 289,663		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ 244,821		37

<sup>\*</sup>These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.) 1 2

(Se	e instructions.)	1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Page 5A

Heritage Manor-Gillespie

| ID# | 0041517 | Report Period Beginning: | 1/01/2002 | Ending: | 12/31/2002

Sch. V Line

	NON-ALLOWABLE EXPENSES		Amount	Reference	
1		\$	0	0	1
2			0	0	2
3			0	0	3
4			0	0	4
5			(1,119)	35	5
6			0	34	6
7			0		7
8			0		8
9			0	30	9
10				32	10
11		_	0		11
12		-	0		12
13		-	(857)	2	13
14			0	32	14
15		-	0	33	15
16			0	24	16
17			(916)	20	17
18			0	20	18
			U	24	_
19			((4)	24	19
20			(64)	27	20
21			0		21
22			(745)	19	22
23			0		23
24			(24,000)	27	24
25			(6,279)	20	25
26			0	0	26
27			0	0	27
28			0	0	28
29			0	0	29
30			0	0	30
31			0	0	31
32					32
33			0	33	33
34					34
35					35
36			_		36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44		_			44
45		_			45
46					46
47					47
48					48
49	Total		(33,980)		48
49	Total		(33,860)		49

Summary A Facility Name & ID Number Heritage Manor-Gillespie
SUMMARY OF PAGES 5. 5A, 6. 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I # 0041517 Report Period Beginning: 1/01/2002 12/31/2002 **Ending:** 

	SUMMARY OF PAGES 5, 5A, 6, 6A	<u>, 6B, 6C, 6D, 6</u>	6E, 6F, 6G, 6H	I AND 6I										
													SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	l
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 <b>G</b>	6Н	6I	(to Sch V, col	.7)
1	Dietary	0	0	4,043	0	0	0	0	0	0	0	0	4,043	1
2	Food Purchase	(857)	0	0	0	0	0	0	0	0	0	0	(857)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,258	0	0	0	0	0	0	0	0	1,258	5
6	Maintenance	0	0	10,880	0	0	0	0	0	0	0	0	10,880	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(857)	0	16,181	0	0	0	0	0	0	0	0	15,324	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	103,987	0	0	0	0	0	0	0	0	0	103,987	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	2,248	0	0	0	0	0	0	0	0	2,248	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	103,987	2,248	0	0	0	0	0	0	0	0	106,235	16
	C. General Administration													
17	Administrative	0	0	104,490	0	0	0	0	0	0	0	0	104,490	17
18	Directors Fees	0	0	5,546	0	0	0	0	0	0	0	0	5,546	18
19	Professional Services	(745)	(250,292)	10,441	0	0	0	0	0	0	0	0	(240,596)	19
20	Fees, Subscriptions & Promotions	(7,195)	0	4,300	0	0	0	0	0	0	0	0	(2,895)	20
21	Clerical & General Office Expenses	0	0	219,782	0	0	0	0	0	0	0	0	219,782	21
22	Employee Benefits & Payroll Taxes	0	0	28,739	0	0	0	0	0	0	0	0	28,739	22
23	Inservice Training & Education	0	0	902	0	0	0	0	0	0	0	0	902	23
24	Travel and Seminar	(10,818)	0	7,023	0	0	0	0	0	0	0	0	(3,795)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,117	0	0	0	0	0	0	0	0	2,117	26
27	Other (specify):*	(24,064)	0	0	0	0	0	0	0	0	0	0	(24,064)	27
28	TOTAL General Administration	(42,822)	(250,292)	383,340	0	0	0	0	0	0	0	0	90,226	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(43,679)	(146,305)	401,769	0	0	0	0	0	0	0	0	211,785	29

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Gillespie # 0041517 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

### SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 <b>G</b>	6H	6I	(to Sch V, col	.7)
30	Depreciation	0	0	0	10,325	0	0	0	0	0	0	0	10,325	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(44)	0	0	259	0	0	0	0	0	0	0	215	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	7,930	0	0	0	0	0	0	0	7,930	34
35	Rent-Equipment & Vehicles	(1,119)	0	0	15,685	0	0	0	0	0	0	0	14,566	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,163)	0	0	34,199	0	0	0	0	0	0	0	33,036	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(44,842)	(146,305)	401,769	34,199	0	0	0	0	0	0	0	244,821	45

0041517

### VII. RELATED PARTIES

1. Enter below the hames of ALL owners and related organizations (parties) as defined in the mistractions. Attach an additional schedule if necessary	<ol> <li>Enter below the names of ALL owners and related org</li> </ol>	anizations (parties) as defined in the instructions. Attach an addition	onal schedule if necessary.
---	---	---	-----------------------------

1		2				3			
OWNERS		RELATED NURSING HOMES				OTHER RELATED BUSINESS ENTITIES			
Name	Ownership %	Name		City		Name	City		Type of Business
			-						
<u> </u>			·						
			<del></del>						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V	10a	Adjustment for Related Organizat	tion 70,420	GreenTree Therapy	100.00%	65,354	(5,066)	2
3	V								3
4	V	19	Adjustment for Related Organizat	tion 250,292	Heritage Enterprises, Inc.	100.00%		(250,292)	4
5	V								5
6	V	10a	Adjustment for Related Organizat	tion 197,526	GreenTree Pharmacy	100.00%	306,579	109,053	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			s 518,238			\$ 371,933	s * (146,305)	14

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS	Page 6A
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Facility Name & ID Number	Heritage Manor-Gillespie	#	0041517	Report Period Beginning:	1/01/2002	Ending:	12/31/2002	
VII. RELATED PARTIES (continued)								
		nis includes ren	t,					

NO

YES

 $If yes, costs incurred \ as \ a \ result \ of \ transactions \ with \ related \ organizations \ must \ be \ fully \ itemized \ in \ accordance \ with$ 

the instructions for determining costs as specified for this form.

management fees, purchase of supplies, and so forth.

1	noti act	2	or determining costs as specified for		5 C (4 D 1 ( 10 ) 1 d		_	0 D:ce	
1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Schedule	<b>V</b>	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Enterprises, Inc.	100.00%	s 4,043	\$ 4,043	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				0		17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				1,258	1,258	19
20	V	6	Maintenance				10,880		20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V		Social Service				0		25
26	V	13	Nurse Aide Training				2,248	2,248	26
27	V	14	Program Transportation				0		27
28	V		Other				0		28
29	V	17	Administrative				104,490	104,490	29
30	V	18	Directors Fees				5,546	5,546	30
31	V	19	Professional Services				10,441	10,441	31
32	V	20	Fees, Subscription, Promotions				4,300		32
33	V	21	Clerical & General Office Expenses				219,782		33
34	V	22	Employee Benefits & Payroll Taxes				28,739		34
35	V	23	Inservice Training & Education				902		35
36	V	24	Travel and Seminar				7,023	7,023	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				2,117	2,117	38
39 Tota	ıl			\$			s 401,769	s * 401,769	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

	STATE OF ILLINOIS	Page 6B
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Facility Name & ID Number Heritage Manor-Gillespie	#	0041517	Report Period Beginning:	1/01/2002	Ending:	12/31/2002	
VII. RELATED PARTIES (continued)  B. Are any costs included in this report which are a result of transactions with related organizations? This include management fees, purchase of supplies, and so forth.  YES  NO	les ren	t,					
If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance	e with						

....

the instructions for determining costs as specified for this form. 3 Cost Per General Ledger 5 Cost to Related Organization 6 8 Difference: Percent **Operating Cost** Adjustments for Schedule V Line Item Name of Related Organization of Related **Related Organization** Amount of Ownership Organization Costs (7 minus 4) 15 27 Other Heritage Enterprises, Inc. 100.00% \$ 15 16 30 Depreciation 10,325 10,325 16 17 31 Amortization of Pre-Op & Org 17 18 32 259 259 18 Interest V 33 19 Real Estate Taxes 19 34 7,930 7,930 20 20 Rent-Facility & Grounds 35 Rent-Equipment & Vehicles 21 15,685 15,685 21 22 22 V 36 Other 0 38 Medically Nec Transportation 23 V 0 23 24 25 V 39 Ancillary Service Centers 0 24 0 25 V Barber and Beauty Shops 26 V 41 Coffee and Gift Shops 0 26 27 27 V 42 Other 0 28 V 28 29 V 29 30 V 30 31 V 31 32 V 32 33 34 35 36 37 V 33 V 34 V 35 V 36 V 37 38 V 38 39 Total 34,199 \$ \* 34,199

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

Page 7 Heritage Manor-Gillespie 0041517 **Report Period Beginning:** 12/31/2002 Facility Name & ID Number 1/01/2002 **Ending:** 

# VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6	5	7		8	
						Average Hou	rs Per Work				
					Compensation	Week Devo	oted to this	Compensation	on Included	Schedule V.	
					Received	Facility and	% of Total	in Costs	for this	Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Bill Froelich	Chairman of Board	Management	26.00	397,396	5	100.00	Director/Salar	\$ 19,530	line 17/18, col	1
2	Tom Jefferson	Asst Secretary/Treasu	Management	10.00	390,860	5	100.00	Director/Salar	y 19,209	line 17/18, col	2
3	Craig Hart	Secretary/Treasurer	Management	20.00	343,058	10	100.00	Director/Salar	y 16,860	line 17/18, col	3
4	Joe Warner	President	Management	2.50	370,366	40	100.00	Director/Salar	y 18,202	line 17/18, col	4
5	Bob Dickson	<b>Executive Vice Presid</b>	Management	0.80	92,266	40	100.00	Salary	4,535	line 17, col 7	5
6	Cheryl Lowney	<b>Executive Vice Presid</b>	Management	0.30	186,564	50	100.00	Director/Salar	y 9,169	line 17/18, col	6
7	Steve Wannemacher	<b>Executive Vice Presid</b>	Management	0.30	175,068	50	100.00	Director/Salar	y 8,604	line 17/18, col	7
8	Connie Hoselton	Sr Vice President	Management	0.17	140,191	40	100.00	Salary	6,890	line 17, col 7	8
9	Craig Ater	Sr Vice President	Management	0.21	143,176	50	100.00	Salary	7,037	line 17, col 7	9
10											10
11											11
12											12
13								TOTAL	\$ 110,036		13

<sup>\*</sup> If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

<sup>\*\*</sup> This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS Page 8

Facility Name & ID Number Heritage Manor-Gillespie # 0041517 Report Period Beginning: 1/01/2002 Ending: 2/31/2002

### VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)  YES  NO  xx	City / State / Zip Code	
<del>_</del>	Phone Number	( )
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5		6	7	8	9	T
	Schedule V	-	Unit of Allocation	•	Number of		Total Indirect	Amount of Salary	Ü	,	
	Line		(i.e.,Days, Direct Cost,		Subunits Being		Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among		Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			Beds	2,401	Anocated Among	\$	82.266	\$ 82,266	118		1
2	2	•	Beds	2,401 2,401	24	J	02,200	0 02,200	118	3 4,043	2
3	<u> </u>			,	24	-	0	0	118	<u> </u>	3
		1 0	Beds	2,401			-	0	118	<u> </u>	
4			Beds	2,401	24		0	0		1250	4
5			Beds	2,401	24		25,593	U	118	1,258	5
6		11 11 11 11	Beds	2,401	24	<u> </u>	221,381	58,785	118	10,880	6
7			Beds	2,401	24	<u> </u>	0	0	118	0	7
8			Beds	2,401	24		0	0	118	0	8
9	10		Beds	2,401	24		0	0	118	0	9
10	11		Beds	2,401	24		0	0	118	0	10
11			Beds	2,401	24		0	0	118	0	11
12			Beds	2,401	24		45,737	39,267	118	2,248	12
13	14	Program Transportation	Beds	2,401	24		0	0	118	0	13
14	15	Other	Beds	2,401	24		0	0	118	0	14
15	17	Administrative	Beds	2,401	24		2,126,096	2,126,096	118	104,490	15
16	18	Directors Fees	Beds	2,401	24		112,849	0	118	5,546	16
17	19	Professional Services	Beds	2,401	24		212,454	0	118	10,441	17
18	20	Fees, Subscription, Promotions	Beds	2,401	24		87,500	0	118	4,300	18
19	21	Clerical & General Office Expense	Beds	2,401	24		4,472,002	4,183,145	118	219,782	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,401	24		584,769	0	118	28,739	20
21	23	Inservice Training & Education	Beds	2,401	24		18,362	0	118	902	21
22	24	Travel and Seminar	Beds	2,401	24		142,902	0	118	7,023	22
23	25	Other Admin. Staff Transportatio	Beds	2,401	24		0	0	118	0	23
24			Beds	2,401	24		43,070	0	118	2,117	24
25	TOTALS	·				\$	8,174,981	\$ 6,489,559		\$ 401,769	25

STATE OF ILLINOIS	Page 8A

Facility Name & ID Number	Heritage Manor-Gillespie	#	0041517	Report Period Beginning:	1/01/2002	Ending:	2/31/2002	
VIII. ALLOCATION OF INDIR	ECT COSTS			<del></del>				
				Name of Related	Organization			
A. Are there any costs include	ed in this report which were derived from allocations of central	offic	ee	Street Address				
or parent organization cost	ts? (See instructions.) YES NO			City / State / Zip	Code			
				Phone Number		( )		
B. Show the allocation of costs	s below. If necessary, please attach worksheets.			Fax Number		( )		

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	27	Other	Beds	2,401	24	\$	\$	118	\$	1
2		Depreciation	Beds	2,401	24	210,090		118	10,325	2
3	31	Amortization of Pre-Op & Org	Beds	2,401	24			118		3
4		Interest	Beds	2,401	24	5,270		118	259	4
5	33	Real Estate Taxes	Beds	2,401	24			118		5
6		Rent-Facility & Grounds	Beds	2,401	24	161,349		118	7,930	6
7	35	Rent-Equipment & Vehicles	Beds	2,401	24	319,142		118	15,685	7
8		Other	Beds	2,401	24			118		8
9			Beds	2,401	24			118		9
10		Ancillary Service Centers	Beds	2,401	24			118		10
11		Barber and Beauty Shops	Beds	2,401	24			118		11
12	41	Coffee and Gift Shops	Beds	2,401	24			118		12
13	42	Other	Beds	2,401	24			118		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24		·-		<u> </u>						24
25	TOTALS					\$ 695,851	\$		\$ 34,199	25

Heritage Manor-Gillespie

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	ì	2		3	4	5	,	6	7	8	9	10	
	Name of Lender	Relate YES		Purpose of Loan	Monthly Payment Required	Date of Note		Amou Original	nt of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related	TES	110		Required	11010		Originar	Balance		(4 Digits)	Expense	
	Long-Term												
1	National City		XX	Mortage	\$28,143.00	03/01/96	\$	3,385,859	\$ 2,978,931	01/15/06	variable	\$ 148,116	1
2	National City Loan Amortizatio	n	XX	Mortgage								6,240	2
3	Central Office Allocation			Interest Income									3
4	Alpha Community Bank		XX			05/01/01		104,710	83,769			4,188	4
5													5
	Working Capital												
6	<b>Central Office Allocation</b>			Working Capital								20,233	6
7	<b>Central Office Allocation</b>		XX	Working Capital								259	7
8													8
9	TOTAL Facility Related				\$28,143.00		<b>s</b>	3,490,569	\$ 3,062,700			\$179,036	9
	B. Non-Facility Related*					T							
10	Interest Income											(44)	
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$ (44)	) 14
15	TOTALS (line 9+line14)						\$	3,490,569	\$ 3,062,700			\$ 178,992	15

<b>16)</b> Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$	Line #
---	----	--------

<sup>\*</sup> Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

<sup>\*\*</sup> If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
# 0041517 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

Facility Name & ID Number Heritage Manor-Gillespie
IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

# K. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued) R. Real Estate Taxes

B. Real Estate Taxes						
	Important, please see the next worksheet, "	RE_Tax". The real	estate tax statement and			
1. Real Estate Tax accrual used on 2001 report.	bill must accompany the cost report.			\$	25,130	1
2. Real Estate Taxes paid during the year: (Indicate the	tax year to which this payment applies. If payment cover	s more than one year, de	tail below.)	\$	25,199	2
3. Under or (over) accrual (line 2 minus line 1).				s	69	3
4. Real Estate Tax accrual used for 2002 report. (Detail	and explain your calculation of this accrual on the lines	below.)		s	26,459	4
**	s NOT been included in professional fees or other generates of invoices to support the cost and a cop			\$		5
6. Subtract a refund of real estate taxes. You must offse classified as a real estate tax cost plus one-half of any TOTAL REFUND \$ For	7 11	ıl estate tax appeal	board's decision.)	s		6
7. Real Estate Tax expense reported on Schedule V, line	2 33. This should be a combination of lines 3 thru 6.			\$	26,528	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year: 199	7 8		FOR OHF USE ONLY			
1996 1999		13	FROM R. E. TAX STATEMENT FO	OR 2001 \$		13
200 200	·	14	PLUS APPEAL COST FROM LINI	E 5 \$		14
		15	LESS REFUND FROM LINE 6	\$		15

NOTES:

- 1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
  application for real estate tax exemption unless the building is rented from a for-profit entity.
  This denial must be no more than four years old at the time the cost report is filed.

### IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

### 2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME	Heritage Manor-	Gillespie					COUNTY	MACOU	PIN	
FAC	ILITY IDPH LICE	ENSE NUMBER	0041517			_					
CON	TACT PERSON I	REGARDING THI	S REPORT	Craig Ater		_					
TELI	EPHONE (309	)823-7135			FAX#:	(	)				
A.		al Estate Tax Cost									
	Enter the tax inde	ex number and real to the operation of thich is vacant, rent	estate tax ass	ome in Colu	mn D. R	eal esta	ite tax	applicable to	any portio	n of th	e nursing
	entered in Colum	n D. Do not includ	le cost for an	y period oth	er than ca	lendar	year 2	2001.			
	(A	)		(B)				(C)			(D)
	Tax Index	Number	Pron	erty Descrip	ntion			Total Tax			Tax olicable to sing Home
1.	1000040001	- Turnser	Nursing Ho		<u> </u>		\$		\$		25,128.00
2.	1000278402	-	Nursing Ho			_	_	71.00	_		71.00
3.						_	_		_		
4.		-				_	\$		\$		
5.							\$				
6.						_	\$				
7.						_	\$				
8.						_	\$		_ \$		
9.						_	\$		\$		
10.						_	\$		_ \$		
				,	TOTALS	;	\$	25,199.00	s		25,199.00
B.	Real Estate Tax	Cost Allocations									
	Does any portion used for nursing l	of the tax bill appl home services?		n one nursir YES	ng home,	vacant NO	prope	rty, or propert	y which is	not di	rectly
		explanation & a so al estate tax cost m								home.	

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

C. Tax Bills

Page 10A

STAT	EOE	TITI	MAIC

27,045

Page 11

Facility Name & ID Number Heritage Manor-Gillespie 0041517 Report Period Beginning: 1/01/2002 Ending: 12/31/2002 X. BUILDING AND GENERAL INFORMATION: 33,800 **B.** General Construction Type: Brick/Wood **Number of Stories** Square Feet: Exterior Frame (c) Rent from Completely Unrelated Does the Operating Entity? xx (a) Own the Facility (b) Rent from a Related Organization. Organization. (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.) xx (a) Own the Equipment (c) Rent equipment from Completely Does the Operating Entity? (b) Rent equipment from a Related Organization. Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.) List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable). YES NO Does this cost report reflect any organization or pre-operating costs which are being amortized? XX If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) XI. OWNERSHIP COSTS: 2 3 Square Feet Year Acquired A. Land. Use Cost Land 27,045

3 TOTALS

# 0041517

Report Period Beginning:

Page 12 1/01/2002 Ending: 12/31/2002

10 11 12 13 14 15 16 17	B. Build	ing Depreciation-Including Fixed Ed	quipment. (See inst	ructions.) Roun	a an numbers to near	est dollar.			. 0	1 0	
5 6 7 8 9 10 11 12 13 14 15 16 17	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	6 Life in Years	Straight Line Depreciation	8 Adjustments	Accumulated Depreciation	
6 7 8 9 10 11 12 13 14 15 16 17 18	118		riequireu	Constructed	\$ 3,578,055	S	111 1 0 111 5	S	S	S	4
6 7 8 9 10 11 12 13 14 15 16 17 18	110				5,070,000	Ψ		Ψ	Ψ		5
7 8 9 10 11 12 13 14 15 16 17											6
9 10 11 12 13 14 15 16 17											7
10 11 12 13 14 15 16 17											8
10 11 12 13 14 15 16 17	Impr	ovement Type**									
10 11 12 13 14 15 16 17	Roof Repair			1997	2,275						9
12 13 14 15 16 17 18	Storage Tank	k		1997	1,857						10
13 14 15 16 17 18											11
14 15 16 17 18	Heritage Man			1996	1,896						12
15 16 17 18	Laundry Roo	om A/C		1996	3,019						13
16 17 18											14
17 18	Garbage Disp	posal		1998	730						15
18	Roof			1998	90,404						16
	W. d. H. d.			1000	7.50/						17
10	Water Heater Air Condition			1999 1999	3,596 1,145						18 19
		pers/Fire Alarm Replacement		1999	5,802						20
21	Interior Pain	itingMaterials and Labor		1999	2,459						21
	Roof	itingMaterials and Labor		1999	29,985						22
23	14001			1,,,,	27,703						23
	Interior Pain	tingMaterials and Labor		2000	3,923						24
25					- 7						25
26	<b>Booster Heat</b>	ter		2001	1,903						26
	Telephone Sy	ystem Add-on		2001	62						27
28											28
	A/C Rooftop	Unit		2002	2,703						29
30											30
31										-	31
32		·									32
33		·						10.225	10 225		33
	C/O Allocation					02.777		10,325	10,325	(30 550	34
35	Book Deprec	aation				93,766		93,766	1	628,779	35

See Page 12A, Line 70 for total

<sup>\*</sup>Total beds on this schedule must agree with page 2.
\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Page 12A 1/01/2002 Ending: 12/31/2002 Facility Name & ID Number Heritage Manor-Gillespie # 004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0041517 Report Period Beginning:

B. Building Depreciation-Including Fixed Equipment. (See instr	3	4	5	6	7	8	9	$\neg \neg$
•	Year	•	Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
37		S	S	III Tears	S		\$	37
38		9	J		φ	<b>J</b>	9	38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,729,814	\$ 93,766		\$ 104,091	\$ 10,325	\$ 628,779	70

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

1/01/2002 Ending: Page 12B 12/31/2002 Facility Name & ID Number Heritage Manor-Gillespie # 004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar. # 0041517 Report Period Beginning:

B. Building Depreciation-Including Fixed Equipment. (	See instructions.) Roun	d all numbers to nea					0	
1	3	4	5	6		8	9	'
	Year	_	Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12A, Carried Forward		s 3,729,814	\$ 93,766		\$ 104,091	\$ 10,325	\$ 628,779	1
2								2
3								3
4								4
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26								26
27								27
28								28
29								29
30								30
31								31
32							·	32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,729,814	\$ 93,766		\$ 104,091	\$ 10,325	\$ 628,779	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

STAT	$\mathbf{F} \mathbf{O} \mathbf{F}$	TT T	INICIC

Page 13 Facility Name & ID Number Heritage Manor-Gillespie 0041517 **Report Period Beginning:** 1/01/2002 12/31/2002 **Ending:** 

### XI. OWNERSHIP COSTS (continued)

C. E	Equipm	ent De	preciation-	Exclud	ing [	[rans	portation.	(See	instructi	ions.)	)
------	--------	--------	-------------	--------	-------	-------	------------	------	-----------	--------	---

	Category of	ı î	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 434,238	\$ 60,875	\$ 60,875	\$		\$ 382,274	71
72	Current Year Purchases	11,351						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 445,589	\$ 60,875	\$ 60,875	\$		\$ 382,274	75

### D. Vehicle Depreciation (See instructions.)\*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

### E. Summary of Care-Related Assets

1	Z

		Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,202,448	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 154,641	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 164,966	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,325	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,011,053	85

### F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	S	\$	S	91

### G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

Facility Na	ıme & ID Number	Heritage Manor-Gill	espie		STATE OF ILLINOIS # 0041517	Report	Period Beginning:	1/01/2002	Ending:	Page 14 12/31/2002
A. Bu 1. N: 2. De	ame of Party Holding	ay real estate taxes in <mark>addi</mark>		amount shown below on		NO				
	1 Year	2 Number	3 Date of	4 Rental	5 Total Years	6 Total Years				
Origi 3 Build	Constructorial ling:		Lease \$	Amount	of Lease	Renewal Option*	3 Beginni	ive dates of curren		ment:
4 Addit 5 6	tions						4 Ending 5 6 11. Rent t	o be paid in future	vears under	he current
7 TOTA	AL		\$	**				agreement:	jeurs under	
TI b		ortization of lease expense lated by dividing the total se	amount to be :		*		Fiscal V 12. 13. 14.	/ear Ending /2003 /2004 /2005	Annual R  S S S	ent
15. Î	is Movable equipmen	Fransportation and Fixed trental included in building ovable equipment:	ng rental?	ee instructions.)  Description:	pager, computer equip		down of movable equip	oment)		
C. Ve	ehicle Rental (See inst	ructions.)			`			,		
	1 Use	2 Model Year and Make	М	3 onthly Lease Payment	4 Rental Expense for this Period			ere is an option to		
17 18			\$		\$	17 18		se provide complet dule.	e details on a	tached
19 20						19				floor
20 21 TOT	AT.		S		\$	20		amount plus any a		

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)  1. HAVE YOU TRAINED AIDES YES 2. CLASSROOM PORTION:  DURING THIS REPORT NO IN-HOUSE PROGRAM IN-HOURS PER AIDE  B. EXPENSES  ALLOCATION OF COSTS (d)  ALLOCATION OF COSTS (d)  To proposits Completed Contract Total In the box below record the amount of income your facility received training aides from other facilities.  To proposite Total Income your facility received training aides from other facilities.  To proposite Total Income your facility received training aides from other facilities.	XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)  A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)  1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? NO IN-HOUSE PROGRAM I				S	TATE OF ILLIN	NOIS					Page 15
A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)  1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? NO IN-HOUSE PROGRAM IN-HOUSE P	A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)  1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? NO IN-HOUSE PROGRAM IN-HOUSE PROGRAM IN-HOUSE PROGRAM IN OTHER FACILITY IN OTHER FACILI	Facility N	Jame & ID Number Heritage Manor-	Gillespie			#	0041517	Report Period Beginning:	1/01/2002	<b>Ending:</b>	
1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?  NO IN-HOUSE PROGRAM IN OTHER FACILITY If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.  B. EXPENSES  ALLOCATION OF COSTS (d)  ALLOCATION OF COSTS (d)  The box below record the amount of income your facility received training aides from other facilities.  The box below record the amount of income your facility received training aides from other facilities.  The box below record the amount of income your facility received training aides from other facilities.  The box below record the amount of income your facility received training aides from other facilities.	1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?  NO IN-HOUSE PROGRAM	XIII. EXP	PENSES RELATING TO NURSE AIDE TRAIN	ING PROGRAMS (See in	structions.)							
1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?  NO IN-HOUSE PROGRAM IN OTHER FACILITY If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.  B. EXPENSES  ALLOCATION OF COSTS (d)  ALLOCATION OF COSTS (d)  The box below record the amount of income your facility received training aides from other facilities.  The box below record the amount of income your facility received training aides from other facilities.  The box below record the amount of income your facility received training aides from other facilities.  The box below record the amount of income your facility received training aides from other facilities.	1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?  NO IN-HOUSE PROGRAM											
DURING THIS REPORT PERIOD?  NO IN-HOUSE PROGRAM IN-HOUSE	DURING THIS REPORT PERIOD?    NO   IN-HOUSE PROGRAM   IN-HOUSE PROGRAM	A. T	YPE OF TRAINING PROGRAM (If aides are t	rained in another facility	program, attach a	schedule listing t	he facility n	ame, address	s and cost per aide trained in t	hat facility.)		
DURING THIS REPORT PERIOD?  NO IN-HOUSE PROGRAM IN-HOUSE	DURING THIS REPORT PERIOD?    NO   IN-HOUSE PROGRAM   IN-HOUSE PROGRAM		1 HAVE VOUEDAINED AIDEC	NEC 2	CI ACCDOOM	DODTION.			2 CLINICAL DO	DTION.		
PERIOD?    NO   IN-HOUSE PROGRAM   IN-HOUSE PROGRAM	PERIOD?    NO   IN-HOUSE PROGRAM   IN-HOUSE PROGRAM			YES 2	. CLASSROOM	PORTION:			3. CLINICAL PC	OKTION:	_	
IN OTHER FACILITY  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.  B. EXPENSES  ALLOCATION OF COSTS (d)  ALLOCATION OF COSTS (d)  In the box below record the amount of income your facility received training aides from other facilities.    Drop-outs   Completed   Contract   Total	B. EXPENSES  ALLOCATION OF COSTS (d)  B. EXPENSES  ALLOCATION OF COSTS (d)  In the box below record the amount of income yor facility received training aides from other facility  Drop-outs Completed Contract Total  Community College Tuition S S S S D. S S S Classroom Wages (a) 3,628  4. Clinical Wages (b) 5. In-House Trainer Wages (c)			NO.	IN_HOUSE PR	OCRAM			IN_HOUSE PE	OCRAM		
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.  B. EXPENSES  ALLOCATION OF COSTS (d)  ALLOCATION OF COSTS (d)  In the box below record the amount of income your facility received training aides from other facilities.  Drop-outs Completed Contract Total  Community College Tuition \$ \$ \$ \$ \$	B. EXPENSES  ALLOCATION OF COSTS (d)  ALLOCATION OF COSTS (d)  In the box below record the amount of income yo facility received training aides from other facilities    Community College Tuition   S   S   S		TERIOD:	110	IN-HOUSE I K	OGRAM			IN-HOUSE I I	KOGKAM		
of this schedule. If "no", provide an explanation as to why this training was not necessary.  HOURS PER AIDE  B. EXPENSES  ALLOCATION OF COSTS (d)  ALLOCATION OF COSTS (d)  In the box below record the amount of income your facility facility received training aides from other facilities.    Drop-outs   Completed   Contract   Total	B. EXPENSES  ALLOCATION OF COSTS (d)  ALLOCATION OF COSTS (d)  In the box below record the amount of income yo facility received training aides from other facilities  Community College Tuition  B. EXPENSES  C. CONTRACTUAL INCOME  In the box below record the amount of income yo facility received training aides from other facilities  Community College Tuition  Completed Contract Total  Community College Tuition  Completed Contract Total  Community College Tuition  Completed Contract Total  Completed Con				IN OTHER FA	CILITY			IN OTHER FA	CILITY		
of this schedule. If "no", provide an explanation as to why this training was not necessary.  HOURS PER AIDE  B. EXPENSES  ALLOCATION OF COSTS (d)  ALLOCATION OF COSTS (d)  In the box below record the amount of income your facility facility received training aides from other facilities.    Drop-outs   Completed   Contract   Total	B. EXPENSES  ALLOCATION OF COSTS (d)  ALLOCATION OF COSTS (d)  In the box below record the amount of income yo facility received training aides from other facilities  Community College Tuition  B. EXPENSES  C. CONTRACTUAL INCOME  In the box below record the amount of income yo facility received training aides from other facilities  Community College Tuition  Completed Contract Total  Community College Tuition  Completed Contract Total  Community College Tuition  Completed Contract Total  Completed Con		If "yes", please complete the remainder									
B. EXPENSES  ALLOCATION OF COSTS (d)  1 2 3 4 facility received training aides from other facilities.  Facility   Drop-outs   Completed   Contract   Total   S   S   S   S	B. EXPENSES  ALLOCATION OF COSTS (d)  ALLOCATION OF COSTS (d)  In the box below record the amount of income yo facility received training aides from other facilities    Drop-outs   Completed   Contract   Total				COMMUNITY	COLLEGE			HOURS PER A	AIDE		
B. EXPENSES  ALLOCATION OF COSTS (d)  1 2 3 4  Facility Drop-outs Completed Contract Total 1 Community College Tuition  S S S S	B. EXPENSES  ALLOCATION OF COSTS (d)  In the box below record the amount of income yo facility received training aides from other facilities    Drop-outs   Completed   Contract   Total		explanation as to why this training was				<u> </u>					
ALLOCATION OF COSTS (d)  1 2 3 4  Facility   Community College Tuition   S   S   S    ALLOCATION OF COSTS (d)  In the box below record the amount of income your facility received training aides from other facilities.	ALLOCATION OF COSTS   (d)		not necessary.		HOURS PER A	AIDE						
ALLOCATION OF COSTS (d)  1 2 3 4  Facility   Community College Tuition   S   S   S    ALLOCATION OF COSTS (d)  In the box below record the amount of income your facility received training aides from other facilities.	ALLOCATION OF COSTS   (d)											
ALLOCATION OF COSTS (d)  1 2 3 4  Facility   Community College Tuition   S   S   S    ALLOCATION OF COSTS (d)  In the box below record the amount of income your facility received training aides from other facilities.	ALLOCATION OF COSTS   (d)											
In the box below record the amount of income your facility received training aides from other facilities.    Sommunity College Tuition   Sompleted   Contract   Total   Sompleted   Somple	In the box below record the amount of income yo facility received training aides from other facilities    Drop-outs   Completed   Contract   Total	<b>B.</b> E.	XPENSES						C. CONTRACTUAL I	NCOME		
1 2 3 4 facility received training aides from other facilities.    Facility	1   2   3   4   facility received training aides from other facilities			ALLOCATI	ON OF COSTS	(d)						
Facility   Drop-outs   Completed   Contract   Total   S   S   S   S	Facility   Drop-outs   Completed   Contract   Total   S   S   S   S   S   S   S   S   S				_							
Drop-outs Completed Contract Total  Community College Tuition \$ \$ \$ \$	Drop-outs   Completed   Contract   Total			1	2	3		4	facility received	d training aide	s from othe	r facilities.
1 Community College Tuition \$ \$ \$	1 Community College Tuition \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ 2 Books and Supplies \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ D. NUMBER OF AIDES TRAINED \$ \$ \$ Complete Tuition \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$					Control		T-4-1			7	
	2 Books and Supplies 3 Classroom Wages (a) 3,628 4 Clinical Wages (b) 5 In-House Trainer Wages (c)  D. NUMBER OF AIDES TRAINED  COMPLETED 1. From this facility	1	Community College Trition	Drop-outs	Completed	Contract	•	1 otai	3		_	
1 2 IDUUKS AHU SUDDIES I D. IVUNIDER OF AIDES I KAINED	3 Classroom Wages (a) 3,628 3,628 4 Clinical Wages (b) COMPLETED 5 In-House Trainer Wages (c) 1. From this facility			3	3	3	3		D NUMBER OF AIDE	C TD AINED		
	4 Clinical Wages (b) 5 In-House Trainer Wages (c) COMPLETED 1. From this facility				3 628			3 628	D. NUMBER OF AIDE	25 I KAINED		
	5 In-House Trainer Wages (c) 1. From this facility		Ů ,		3,020			3,020	COMPLE	TED		
	1 0 11 FAUNDOCIALION 1 12. From other facilities (1)	6	Transportation (c)							,		

3,628

3,628

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

Contractual Payments

TOTALS

Nurse Aide Competency Tests

SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for

3,628

DROP-OUTS

2. From other facilities (f)
TOTAL TRAINED

1. From this facility

your own aides must agree with Sch. V, line 13, col. 8. (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Heritage Manor-Gillespie # 0041517 Report Period Beginning: 1/01/2002 Ending:

### XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
		Schedule V	Stafi	Ī	Outsid	e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other t	han consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	\$		\$ 24,684	\$	\$	24,684	1
	Licensed Speech and Language									
2	Development Therapist	10a/3	hrs			9,851			9,851	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			30,819	1,818		32,637	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy	39/3	prescrpts				301,699		301,699	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): x-ray	39/3				8,960			8,960	13
14	TOTAL			\$		\$ 74,314	\$ 303,517	9	377,831	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

This report must be comp	neteu even ii imanciai statement	s are attached.
	1	2 After

		1		2 After	
		0	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	2,007	\$	1
2	Cash-Patient Deposits		3,444		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance		314,601		3
4	Supply Inventory (priced at )				4
5	Short-Term Investments				5
6	Prepaid Insurance		12,624		6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)		857,414		8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	1,190,090	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		27,045		13
14	Buildings, at Historical Cost		3,729,814		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		445,589		16
17	Accumulated Depreciation (book methods)		(1,011,052)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify): Deferred Tax Asset		18,720		23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	3,210,116	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	4,400,206	\$	25

		1	perating	2 A Cons	After olidation*	
	C. Current Liabilities					
26	Accounts Payable	\$	39,351	\$		26
27	Officer's Accounts Payable					27
28	Accounts Payable-Patient Deposits		3,444			28
29	Short-Term Notes Payable					29
30	Accrued Salaries Payable		194,283			30
	Accrued Taxes Payable					
31	(excluding real estate taxes)		2,578			31
32	Accrued Real Estate Taxes(Sch.IX-B)		26,459			32
33	Accrued Interest Payable		13,935			33
34	Deferred Compensation					34
35	Federal and State Income Taxes					35
	Other Current Liabilities(specify):					
36	Security Deposits		16,284			36
37						37
	TOTAL Current Liabilities					
38	(sum of lines 26 thru 37)	\$	296,334	\$		38
	D. Long-Term Liabilities					
39	Long-Term Notes Payable					39
40	Mortgage Payable		3,062,700			40
41	Bonds Payable					41
42	Deferred Compensation					42
	Other Long-Term Liabilities(specify):					
43						43
44						44
	TOTAL Long-Term Liabilities					
45	(sum of lines 39 thru 44)	\$	3,062,700	\$		45
	TOTAL LIABILITIES					
46	(sum of lines 38 and 45)	\$	3,359,034	\$		46
47	TOTAL EQUITY(page 18, line 24)	\$	1,041,172	\$		47
	TOTAL LIABILITIES AND EQUITY					
48	(sum of lines 46 and 47)	\$	4,400,206	\$		48

<sup>\*(</sup>See instructions.)

Facility Name & ID Number Heritage Manor-Gillespie

XVI. STATEMENT OF CHANGES IN EQUITY

			1	
			Total	
1	Balance at Beginning of Year, as Previously Reported	\$	558,299	1
2	Restatements (describe):			2
3	Audit Adjustment		(18,599)	3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	539,700	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		501,472	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	(	)	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	501,472	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	1,041,172	24

<sup>\*</sup> This must agree with page 17, line 47.

**Ending:** 

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 3,985,897	1
2	Discounts and Allowances for all Levels	(405,489)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,580,408	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	133,888	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 133,888	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	5,485	11
12	Gift and Coffee Shop	3,659	12
13	Barber and Beauty Care	13,417	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	337,407	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	154	21
	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 360,122	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	44	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 44	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ •	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,074,462	30

,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	e agamst expense.	2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	641,596	31
32	Health Care	1,666,899	32
33	General Administration	887,976	33
	B. Capital Expense		
34	Ownership	365,691	34
	C. Ancillary Expense		
35	Special Cost Centers	10,828	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Loss from Non-Nursing property		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,572,990	40
41	Income before Income Taxes (line 30 minus line 40)**	501,472	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 501,472	43

*	This must	t agree with	page 4,	line 45,	column 4.
---	-----------	--------------	---------	----------	-----------

*	Does this agree wit	th taxable income (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation.

<sup>\*\*\*</sup> See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

<sup>\*\*\*\*</sup>Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Manor-Gillespie

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	1,778	1,953	s 42,259	\$ 21.64	1
2	Assistant Director of Nursing	1,751	1,894	31,767	16.77	2
3	Registered Nurses	4,919	5,382	96,679	17.96	3
4	Licensed Practical Nurses	13,813	14,457	238,002	16.46	4
5	Nurse Aides & Orderlies	81,697	86,866	804,100	9.26	5
6	Nurse Aide Trainees	500	500	3,628	7.26	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,659	1,886	20,725	10.99	8
9	Activity Director					9
10	Activity Assistants	4,294	4,796	47,825	9.97	10
11	Social Service Workers	1,892	2,053	28,081	13.68	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,682	18,208	143,528	7.88	15
16	Dishwashers					16
17	Maintenance Workers	3,410	3,794	47,313	12.47	17
	Housekeepers	11,445	11,969	81,553	6.81	18
19	Laundry	5,288	5,470	40,062	7.32	19
20	Administrator	2,080	2,080	65,915	31.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,513	6,274	90,568	14.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	156,721	167,582	s 1,782,005 *	s 10.63	34

<sup>\*</sup> This total must agree with page 4, column 1, line 45.

### B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		1,250		36
37	Medical Records Consultant		50		37
38	Nurse Consultant				38
39	Pharmacist Consultant		690		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,198		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 5,188		49

### C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid &	Total Contract	Schedule V Line & Column	
		Accrued	Wages	Reference	
50	Registered Nurses		<b>\$</b> 6,577		50
51	Licensed Practical Nurses		1,877		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		s 8,454		53

<sup>\*\*</sup> See instructions.

STATE OF ILLINOIS	
# 0041517	Danaut Daviad Daginning

					STATE OF ILLINOI				Page	
Facility Name & ID Number XIX. SUPPORT SCHEDULES	Heritage Manor-Gille	espie			#_0041517	Rep	ort Period Beg	inning: 1/01/2002 En	ding:	12/31/2002
A. Administrative Salaries		Ownershi	in		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Pro	motions	
Name	Function	%	ıþ	Amount	Description		Amount	Description	nonons	Amount
Susie Hale	Administrator	0	\$	65,915	Workers' Compensation Insurance	\$		IDPH License Fee	s	400
Susic Haic	Administrator			03,713	Unemployment Compensation Insurance	<u> </u>	13,711	Advertising: Employee Recruitment		1,772
		-			FICA Taxes		136,323	Health Care Worker Background Ch	eck	1,772
		-			Employee Health Insurance		105,729		0)	294
					Employee Meals			Central Office Allocation		4,300
_					Illinois Municipal Retirement Fund (IMRF	)*		Promotional Advertising		2,779
_		-			Employee Hepatitis Vaccine		1,404	Public Relations		3,500
TOTAL (agree to Schedule V, line	e 17, col. 1)				Employee Benefits -	-	19,578	Dues and Subscriptions		9,049
(List each licensed administrator			\$	65,915	Employee Benefits - central office	-	28,739	License and Fees		3
B. Administrative - Other										
								Less: Public Relations Expense		(3,500)
Description				Amount				Non-allowable advertising		(916)
_			\$					Yellow page advertising		(2,779)
TOTAL (agree to Schedule V, line			- <b>\$</b>		TOTAL (agree to Schedule V, line 22, col.8)  E. Schedule of Non-Cash Compensation Pa	id	326,858	TOTAL (agree to Sch. V. line 20, col. 8) G. Schedule of Travel and Seminar**	=	14,902
(Attach a copy of any managemen	nt service agreement)				to Owners or Employees					
C. Professional Services	TEN.				<b>.</b>			Description		Amount
Vendor/Payee	Туре		•	Amount	Description Line #	en.	Amount	O 4 CSC T - 1	•	
Heritage Enterprises	Management Fee	<u> </u>	_ >_	250,292		\$		Out-of-State Travel	\$_	
				0				-		
				0				In-State Travel		
								III-State Travel		3,159
					<u> </u>					128
				<del></del>						120
				_				Seminar Expense		2,507
						-		Non Allowable		(10,818)
				0				Central Office Allocation		7,023
Legal Fees (Adjusted to zero)				745						
								Entertainment Expense	_ , -	
				0				Entertainment Expense	(	
TOTAL (agree to Schedule V, line	e 19, column 3)			<u> </u>	TOTAL	\$		(agree to Sch. V,	' -	

<sup>\*</sup> Attach copy of IMRF notifications

<sup>\*\*</sup>See instructions.

Page 22 12/31/2002

Report Period Beginning: 1/01/2002 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year Amount of Expense Amortized Per Year											
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
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20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facilit	S y Name & ID Number Heritage Manor-Gillespie		OF ILLINOIS # 0041517	Report Period Beginning:	1/01/2002	Ending:	Page 23 12/31/2002
XX. G	ENERAL INFORMATION:			•			
		(13)		supplies and services which are of the Public Aid, in addition to the daily			
(2)	Are there any dues to nursing home associations included on the cost report? yes  If YES, give association name and amount. Illinois Healthcare Association		,	ection of Schedule V? yes			
(3)	Did the nursing home make political contributions or payments to a political action organization?  no  If YES, have these costs been properly adjusted out of the cost report?  yes	(14)	the patient census is a portion of the	building used for any function other listed on page 2, Section B? no building used for rental, a pharmacy explains how all related costs were a	, day care, etc.)	For example If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?	(15)	Indicate the cost of on Schedule V. related costs?		assified to employ meal income be the amount. \$	oeen offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases?  What was the average life used for new equipment added during this period?  yes  7 years	(16)	Travel and Transp	ortation ncluded for out-of-state travel?	no		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10		If YES, attach a	complete explanation. eparate contract with the Department	nt to provide me		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?   yes   If NO, attach a complete explanation.		c. What percent of	this reporting period. \$ fall travel expense relates to transpour age logs been maintained? yes			
(8)	Are you presently operating under a sale and leaseback arrangement?  If YES, give effective date of lease.		e. Are all vehicles times when not	stored at the nursing home during the			
(9)	Are you presently operating under a sublease agreement? YES xx NO		out of the cost re		-		no
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO no If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over.		Indicate the a transportation	mount of income earned from n during this reporting period.	providing sucl \$	<b>h</b> S	
		(17)	Firm Name: St	performed by an independent certification of the control of the certification of the certific		The instruct	tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 64,605  This amount is to be recorded on line 42 of Schedule V.			that a copy of this audit be included  No If no, please explain.	d with the cost re not available		
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  no If YES, attach an explanation of the allocation.		out of Schedule V			-	
	<u> </u>	(19)	performed been att	re in excess of \$2500, have legal in tached to this cost report?  d a summary of services for all arch			ices

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